SUBMIT FOR PRIOR AUTH REVIEW? ___ Yes ___ No
If yes, _____ Day Tx. ____ RCCY ____ Grp. Home ____ Indep Living, Phase 1

Youth Name: _____

Date of Birth: _____ **POC Date:** _____

REQUIRED TEAM MEMBER SIGNATURES

			In Attendance
Youth	Phone	E-mail address	☐ Yes ☐ No
Parent/Legal Guardian	Phone	E-mail address	☐ Yes ☐ No
Parent/Legal Guardian	Phone	E-mail address	☐ Yes ☐ No
Care Coordinator	Phone	E-mail address	☐ Yes ☐ No
Supervisor	Phone	E-mail address	☐ Yes ☐ No
Consulting Psychologist	Phone	E-mail address	☐ Yes ☐ No
Prescribing Physician	Phone	E-mail address	☐ Yes ☐ No

✓Client Rights Reminder

Youth/parent/ legal guardian:

By signing this form you do not give up your right to grieve or appeal what is written in this Plan or the services you are receiving.

SIGNATURES OF ADDITIONAL TEAM MEMBERS

Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address

Youth Name: _____

Date of Birth: _____ **POC Date:_____**

SIGNATURES OF ADDITIONAL TEAM MEMBERS

Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address